ABSTRACT

Aim: to understand how nurses and midwives manage informal complaints at ward level.

Background: the provision of high quality, compassionate clinical nursing and midwifery is a global priority. Complaints management systems have been established within the National Health Service (NHS) in the United Kingdom (UK) to improve patient experience yet little is known about effective responses to informal complaints in clinical practice by nurses and midwives.

Design: collaborative action research.

Methods: four phases of data collection and analysis relating to primarily one NHS trust during 2011-2014 including: scoping of complaints data, interviews with five service users and six key stakeholders and eight reflective discussion groups with six midwives over a period of nine months, two sessions of communications training with separate groups of midwives and one focus group with four nurses in the collaborating trust.

Results: three key themes emerged from these data: multiple and domino complaints; ward staff need support; and unclear complaints systems.

Conclusions: current research does not capture the complexities of complaints and the nursing and midwifery response to informal complaints.

Relevance to clinical practice: robust systems are required to support clinical staff to improve their response to informal complaints and thereby improve the patient experience.

Key words: health care complaints; midwifery care complaints; nursing care complaints; patient complaints; action research

Summary box

What does this paper contribute to the wider global clinical community?

- Little is known about how ward nurses and midwives respond to informal complaints in spite of a growing body of literature in relation to health care complaints.
- Robust systems to train and support ward nurses and midwives in responding effectively to informal complaints are required.
- Improved service user experiences of clinical care may be achieved through a more transparent communication of 'how the hospital works' and what may be expected in terms of service delivery.

INTRODUCTION

Complaints management systems have been established within the NHS in the UK to improve patient experience and there is an emerging international literature on health care complaints (Stokes *et al*. 2006) indicating that the provision of high quality and compassionate clinical nursing and midwifery is a priority globally. Yet little is known about effective responses to informal complaints in clinical practice by nurses and midwives.

This paper discusses the findings from a UK study, which explored nurses' and midwives' responses to service user informal complaints. The study was prompted by rising numbers of formal complaints within the NHS and a desire to improve patient experience of health services. It focused on informal complaints management at ward level in the UK and adds to developing robust systems to support clinical staff to improve their responses to informal complaints and thereby improve the patient experience.

The findings in this paper should be considered in the light of the Francis Inquiry (DH 2013) and the significant and highly publicised care failings at the Mid Staffordshire Foundation Trust outlined in the Francis reports (Francis 2010, 2013) which is discussed later.

BACKGROUND

While the background to this study is shaped by events in the UK (Department of Health [DH] 2009; Francis 2013), international research into the link between complaints, quality of services and safety control is recognised in international literature (Cowan & Anthony 2008; Jonsson & Ovretveit 2008; Hsieh 2010;). Research indicates that communication failure

coupled with a failure to take account of a service user perspective, are common causes of complaints (Coulter 2002). Other research into complaints suggests that *how* complaints are managed is especially important for service users (Allsop & Mulcahy 1995); if dissatisfaction is handled effectively and openly, formal, written complaints may be avoided. Complaints are associated with managing clinically complex conditions (Kline *et al*. 2007); and with a failure to communicate rather than a lack of clinical skills (Donaldson & Cavanagh 1992). Pearson *et al*. (2010) in their study of service user safety found that an important driver to focus staff on quality is strong leadership and in particular, fostering a no-blame culture.

There is evidence that good management practice by clinical leaders can result in good service user outcomes (Thyer 2003; Shipton *et al*. 2008). Effective leaders shape organisational outcomes through the allegiance of individuals and teams, vision and enabling organisations to respond to change (Shipton *et al.* 2008). Good service user and organisational outcomes raise morale and continue a cycle of service user and staff satisfaction (Borrill *et al.* 2000). To achieve good leadership and promote high quality standards, clinical leaders need to be effective communicators with junior staff (Revans 1964) and have authority (Degeling & Carr 2004).

The Patients Association UK (2008) and the UK Parliamentary and Health Service Ombudsman's Report (2010) state that there is a lack of wholehearted commitment to any complaints system, an inability by some staff to view complaints positively rather than negatively, and to see complaints as an opportunity to improve the service. Junior clinical staff are at

the forefront of handling verbal, informal complaints (Parliamentary and Health Service Ombudsman, 2010). Yet ironically senior staff respond to formal, written complaints and work in small complaints teams gaining expertise in doing so (Allsop & Mulcahy 1995). While informal complaints can improve service delivery if responded to constructively, formal written complaints are seen by the Department of Health as an indicator of poor service delivery (Parliamentary and Health Service Ombudsman, 2010).

A number of reviews and reports have followed in the wake of the Francis reports (Francis, 2010, 2013) such as the Keogh Review (Keogh 2013) looking at the quality of care in a number of NHS trusts with consistently high mortality rates, and that by Cavendish Review investigating training of health care assistants (Cavendish 2014). Another important review is the Clwyd & Hart Review (2014). The Francis reports (Francis 2010, 2013) highlighted issues in complaints management which were considered to have contributed to the serious failures at the Mid Staffordshire Foundation Trust, and this induced the government to initiate the Clwyd and Hart review of NHS hospital complaints handling (2014). Clwyd and Hart were asked by the government to investigate how complaints management could be made less fragmented and more standardised, identify examples of good practice in complaints management, explore the link between complaints and improved services, consider the roles of higher management and frontline staff in complaints management and identify how complainants would be best supported through the complaints process. Their findings suggested that service users complain because they experience poor information-giving, a lack of compassion, lack

of dignity and care, poor staff attitudes and lack of resources. Clwyd and Hart argue that patients felt that "they were a problem or a burden, rather than being cared for" (2014: 16). They also argue that the process of complaining needs to be improved because it leaves service users confused, fearful and frustrated.

There is little research into how complaints are responded to by nursing and midwifery staff at the clinical or ward level. There is some evidence of how doctors and institutions respond to complaints (Stokes *et al.* 2006; Allsop & Mulcahy 1998; Nettleton & Harding 1994; Carmel 1988; Fisher 1984). And one paper by Shojania & Dixon-Woods (2013) written in the light of failures in care delivery such as the Francis Report into the Mid Staffordshire Foundation Trust Public Inquiry (DH 2012; Francis 2013) which addresses trusts' complaints management but does not investigate clinical staff.

METHODS

The RESPONSE project (Responding Effectively to Service users' and Practioners' perspectives On care concerns: developing Sustainable responses through collaborative Educational action research), conducted primarily in one NHS trust, used an Action Research (AR) approach with mixed methods and four cycles of action which is discussed below as well as in a published paper authored by the research team (Odelius *et al.* 2012). Most of the data were collected from the main participating acute NHS trust, apart from the complaints data which were collected from two further NHS trusts. The aim of the project was to explore how nurses and midwives manage complaints at ward level. The project used a complex mixed methods design with four

phases, four action cycles and a number of different forms of participation which is depicted in diagram 1 and discussed below. (Odelius *et al.* 2012). Ethical review was undertaken through the NHS and the University of Surrey.

Diagram 1 insert

Data collection

The 1st phase was preparatory and included the establishment of an action research group (ARG) which was the main route for communication and decision making for the study and ensured representation of different stakeholder interests (Odelius *et al.* 2012). This first full cycle of action was a preparatory, 'pre-reconnaissance', phase consistent with AR (Snoeren & Frost 2011 p, 4) where support was sought and received from key stakeholders, and mutual trust created. Phase 2 entailed a literature review, in-depth interviews with six key trust stakeholders in the main participating acute NHS trust (representing nursing, midwifery, teaching and learning, complaints management and the Patient Advice Liaison Service (PALS), and the collection and scoping of trust complaints data as well as data logged by the Patient Advice and Liaison Service (PALS) and data separately logged by the midwifery services from follow up sessions with service users to which the service users had been referred or had self referred due to a need to reflect on their care following a delivery. Complaints data were also collected and analysed from two further collaborating NHS trusts. Data in phase 2 were collected in preparation for phase 3 which included four action research cycles at the main participating NHS trust to explore informal complaints management among front line midwifery and nursing staff. These action

cycles in phase 3 included:

- Developing and piloting a scale to measure staff self-confidence and experience at responding to informal complaints which is reported else where.
- Semi-structured interviews with five service users who had complained about care. Service users were recruited through the collaborating NHS trust complaints team. The complaints team purposefully selected and sent invitations to 25 recent complainants where nurses or midwives had been involved, excluding complaints involving particular ethical issues or those being processed by the Ombudsman. The invitations included a tear off slip which participants returned to the core project team.

  Eight reflective discussion (RD) groups with midwives held over a period of nine months during 2012-2013 and facilitated by one of the research team (AO) were audio recorded. Six midwives met eight times in RD groups, in total for approximately an hour each time on trust premises, to discuss experiences in relation to informal complaints. Participants were asked to reflect and make notes about significant experiences concerning informal complaints prior to the meetings (Selby 2000).
- All these data were in turn analysed and through discussion with the ARG, a further cycle of action in Phase 3 was started which included a focus group with nurses and two communications training sessions with groups of midwives.

Phase 4 included a 4th action cycle where a further decision was taken by the

ARG to continue the work of the project, namely the communications training with further groups of midwives and nurses. Funding was found to resource these activities by the trust leadership team.

Data analysis

The audio recorded interviews with stakeholders and service users, the midwifery RD groups and the nursing focus group interview were transcribed verbatim and analysed using the soft ware NVivo (QSR 2013).

We have used 'a general inductive approach' similar to that of grounded theory for the analysis, which has generated concepts in response to research questions whilst also allowing unexpected insights to emerge (Thomas 2006 p.237). One member of the project team conducted iterative analysis of the data within and between individual transcripts and data groupings. The analysis generated sub ordinate themes which were then clustered into super ordinate themes creating a coding sceme. The coding scheme was then discussed, revised, and adjusted iteratively with two other members of the research team and then during a data analysis workshop with the research team and discussed with the ARG. The nursing focus group, which was conducted after the data analysis work shop, was coded as described above and the coding checked by three members of the project team, adjusted and pooled with the other data by the project team.

The complaints scoping data from 01/01/2011 – 31/06/2011 which were text entries on the 'datix' database were analysed using content analysis (Graneheim & Lundman, 2004: 106),. The list of entries from each participating trust were read by one researcher who made notes and

developed a understanding of the main issues. Each entry was then individually analysed at a descriptive level. The results of the analysis were subsequently discussed and confirmed with the research team at the analysis workshop and discussed with the ARG.

RESULTS

Although not a superordinate theme, our data showed that there was good practice in the main participating trust around responding to informal complaints, demonstrated through descriptions of empathy, acknowledgement of poor practice and a willingness to listen by the service users we interviewed, the nursing focus group and the RD groups with midwives. All service users, unprompted, talked about the good aspects of care they had experienced in the trust; sometimes in glowing terms which is noteworthy given that the service users were aware that the interviews would relate to their complaints.

Three themes which inform midwifery and nursing practice emerged from the data: multiple and domino complaints, unclear complaints systems, ward staff need support, which are discussed in this paper.

Multiple and domino complaints

The findings suggest that one single complaint can involve [numerous] perceived care failures, and can also be shaped by emotions partly relating to past experiences related to delivery of care or the illness itself. We have called these types of complex complaints *multiple issue* complaints and *domino* complaints. *Multiple issue* complaints entail a single complaint about a

number of different members of staff or a number of issues in sometimes multiple departments of the hospital.

> *You know, the fact that she hadn't been washed and the cannula was left in situ and she had this wound on the leg that she hadn't had when she went in, so that was obviously acquired probably moving her on a trolley or something but it wasn't really dressed properly (…)[staff at care home to which the patient was returned] said 'I was absolutely appalled with the way I found her', 'she hadn't been bathed' she actually smelt (Service user interview)*

Multiple complaints can raise systemic issues, whereby inter related processes function, or do not function which subsequently lead to complaints. The *domino* complaint, a form of multiple complaint, is where the complaint may originate in one part of the organisation and dissatisfaction can then get exacerbated over time by subsequent perceived failures in other areas. This results in an informal or formal complaint that is difficult for staff to untangle and address. Paradoxically, the original issue can in some cases be considered to be much more serious than the issue that finally causes the service user to complain for instance, problems with parking or discharge.

> *She [the mother] was, she suffered a broken ankle, quite badly broken ankle in February of this year falling down a step at home, she was taken to hospital, she had surgery on her ankle and then she was treated in the ward (…) The area where we, I wrote a complaint was about the discharge process. (Service user)*

In the *domino* complaint, service users, although unhappy with aspects of their care, show a threshold of tolerance to a certain point and do not complain until there have been a number of perceived failures. Problems with long waiting periods in Accident & Emergency (A&E) can start off this process.

> *I would say it's like a straw on a camel's back, because, generally, people are very tolerant of the NHS, they understand the pressure that it's under and what you normally find is, there's a whole string of problems that occur (Senior Trust employee)*

Service users were all deeply affected by the poor care which elicited the complaint:

> *It [complaining] still hasn't answered that why he went in there on the Thursday and was dead Tuesday when all they talked about (…) Its just my dad, its my dad, I'll never get over that I don't think, ever, but you move on don't you, you have to, there's, nothing's going to bring him back (service user)*

Service users stressed the need for authenticity in responding to informal or formal complaints and accountability,

> *This is not a 'you upset me a bit by some words that you used', this is a real thing you know, pain relief, it's a real thing. (service user)*

A visit to, or stay in hospital, is often coupled with strong emotions for both patients and carers perhaps involving life changing events such as childbirth at one end of the spectrum or end of life care at the other; and also with high levels of felt and actual *uncertainty.*

And if somebody's anxious then they're more likely to complain (…) You know, and they won't be rational, they won't be reasonable, but then, you know, we've caused that to a certain extent. (Senior trust manager)

Complaints can also involve emotions relating to past life/healthcare experiences, as well as to the actual complaints situation in hand.

But we do, you know for so many families there's actually other stuff going on and they'll go and bite the head off of the staff on the ward (…) (Senior trust manager)

This level of emotion was rarely discussed in the context of complaints management in the RD groups. While stakeholders said they understood the emotional cost of a complaint as in the quotes above, service user data suggests that they felt their complaints were not seen as sufficiently serious by either ward staff or more senior trust staff. This implies the emotional context of complaints is perhaps difficult for both staff and patients to manage.

He didn't die but he could have and they [the Trust] perhaps need to think about that outcome because those are the emotions that the person writing the complaint is going through, what could have happened (service user)

Service users, key stakeholders and the focus group participants all perceived *poor staff communication* as a major cause of complaints; this echoes recent and current national complaints figures from The Information Centre for Health and Social Care (2011; 2012; 2013; 2014).

And I think I'm pretty good at handling a complaint you know, if someone comes up to me and they are aggressive I can diffuse it and I know others that will actually add fuel to that fire. They will make that situation worse (Ward nurse)

This was also evident in the complaints data and in the analysis of the main trust's PALS data. These data also show that PALS remit fulfils an important role in improving communication between service users and their families/carers and the trust staff in the Trust.

The junior staff actually encourage patients to go to PALS and I'm like 'no'. I don't know why … whether that's our age and we're older now in a job and we know what it's like to research, to pull someone's notes and have a look, see who the nurse was, see what happened (…) that's not a very nice attitude to have so dealing with nurses who have got that attitude and (…) just go to PALS, here's the number [is frustrating] (Senior ward manager)

Poor communication encompassed inadequate, ineffective and uncaring communication or attitude. This included poor face-to-face communication between different staff categories and service users, but also poor communication between different staff categories and hospital areas. Poor communication is often attributed particularly to nurses (Clwyd & Hart 2014) however the service users and stakeholder interviews referred to instances of poor communication by all levels of staff including nurses. One stakeholder suggested that it was the functioning of the hospital as a whole which was not communicated effectively.

Yes, yes, it's sort of sometimes we're having to explain how a hospital works and why you know why things take the time they do and why. (Senior manager)

Unclear complaints systems

The call for complaints resolution was echoed across trust X's website, the interviews with key stakeholders as well as in our review of DoH policy. The discourse of complaints resolution across these data implies that complaints can normally be satisfactorily resolved.

[We aim] to try and manage that problem and resolve it and try and eradicate the term 'handling' or 'dealing' and to create the resolution. So our policy is resolving complaints not dealing or handling (Senior manager)

Yet there were hints in the stakeholder interviews that this aspiration was not always a reality.

I think they [staff] accept it [complaints] as normal, you know, you're never going to please everybody and in an environment like this you will never make everybody happy. (Senior manager)

Our service user, RD groups and focus group data illuminated our understanding of this discourse on complaints as we were given instances of complaints not being satisfactorily resolved for the service user at the ward level, the organizational or personal levels.

I just want to feel like they've taken it seriously rather than just kind of, I just feel a bit fobbed off and I just want to be taken seriously because it is, to me it's a very serious complaint. (Service user)

Ward staff need support

Our findings suggest that training within the trust is not based on any knowledge of the training needs of staff skills to respond to informal complaints, i.e. staff have not been asked for their training needs around responding to informal and formal complaints. Data from the RD groups, service user and stakeholder interviews showed that some staff seem unaware of the mechanisms for resolving informal and formal complaints and had poor 'soft skills'.

> *I was a bit like 'what do I do' [when addressing a particular complaint]. (Midwifery RD group)*
>
> *The junior staff actually encourage patients to go to PALS and I'm like 'no' (Nursing focus group)*

Yet data from the key stakeholder interviews indicated that staff felt self confident in responding to such complaints; it seems this self confidence did not translate into effective informal complaints responses at ward level. This discrepancy was reflected in both the PALS data and scoping of the complaints data as this stakeholder reflects.

> *So it's about reminding them [front line staff] all the time about making things personalised to make sure they respond appropriately, their body language as much as what actually comes out of their mouths (Key stakeholder)*

One of the reasons given by a PALS staff member is that ward staff can divert a complaining service user to organisational systems resulting in less and less experience of dealing face to face with informal complaints.

As staff become more responsible for what happens within their area, you know, I would hope that the ward managers would want a situation that every complaint that they receive is dealt with locally, to me that would be a good outcome (…) Whereas I don't have the stats but I suspect that 90% of the complaints gets passed onto PALS or somebody else (Key stakeholder)

We concluded with the ARG in the 4th action cycle in phase 3 that these data suggest a need for more training in this area.

DISCUSSION

Complaints are an increasingly important measure of patient experience in health care contexts globally (see Sidgewick 2006), yet our findings suggest that more work needs to be undertaken to understand the meaning of informal complaints in health care and how ward staff respond effectively to them. Complaints are a reflection of experienced dissatisfaction with healthcare which can be made orally or in writing by service users (patients and/or carers) (Allsop & Mulcahy 1995). Complaints are framed as a reflection of a "violation of the complainant's normative expectations" (Lloyd-Bostock & Mulcahy 1994 p. 123). Our findings suggest that informal complaints are a more complex and ambiguous construct, albeit by most considered less 'serious' than a formal complaint and often put forward verbally (Sidgewick 2006). This, however, does not mean that an informal verbal complaint cannot involve for instance clinical error or that a formal written complaint could involve a less serious non-clinical issue. Nonetheless dissatisfaction does not sufficiently encompass the full extent of the patient and/or carer

experience in relation to negative experiences of healthcare, which can amount to a "'personal identity threat'" and a sense of powerlessness (Coyle 1999a p. 95). Moreover the boundaries between satisfaction and dissatisfaction are blurred in that there is no clear dichotomy or 'either or'. In other words to be satisfied does not preclude being concurrently satisfied and dissatisfied. This complexity informs decisions by service users about whether to make a complaint or not (Mulcahy & Tritter 1998).

It is clear from our findings that a service user complaint can embody everything from a straightforward 'logical' response to instances of sub standard care or clinical errors, to poor communication, to a much less easily quantifiable emotional response to 'something' in and/or outside the health care setting. Moreover the processes leading to a decision about whether or not to complain can be highly complex. Equally, our findings suggest that it can be difficult for staff to address service user complaints accurately and effectively because it is not always clear to staff when a service user 'issue' or a 'concern' begins to be viewed as a complaint as it is a gradual process, or an "evolution of grievances and complaints" and one that, in most cases, can be reversed before it escalates further (Mulcahy & Tritter, 1998: 826 - 827).

The link between complaints and service improvements is a complex area that needs to be further explored and developed. According to key stakeholders, the trust is credited with having fewer midwifery service complaints relative to other trusts, which key stakeholders partly attribute to the 'debriefing service'. However informal complaints continue as testified by the PALS data and interviews, which indicates that while formal complaints may indeed be

falling, service users continue to experience dissatisfaction and proceed to complain informally about perceived failures irrespective of whether they then go onto make a formal complaint.

Limitations

This paper reports findings from a study into complaints management in one hospital trust in the UK. However our finding are based on detailed work with the participating trust over three years and suggest that more work needs to be undertaken internationally and in different cultural settings to understand the social processes of informal complaints management by clinical staff.

CONCLUSIONS

This paper constitutes a timely contribution to the current debate internationally over standards of care and offers some new insights into complaints and complaints management. We conclude that current literature on complaints and the statutory reporting systems do not capture a) the complexities of how complaints arise and why service users or their families/carers complain; b) the emotional context of complaining about poor care; c) level of communication skills and the support required to deal with complaints at ward level; d) the lack of clarity of the existing complaints systems for service users and ward staff.

RELEVANCE TO CLINICAL PRACTICE

Our findings suggest that information about how a hospital works for service users might improve their experience and sense of being cared for; service user expectations of what the service can deliver might also become more realistic. The implications of these findings for clinical practice are as follows:

the complexities involved in communication and managing informal complaints in clinical practice needs to be acknowledged to begin a conversation about how staff can be supported and trained to manage informal complaints effectively. Our findings suggest that regular training opportunities to develop and maintain communication skills for all staff may be beneficial; in particular, the provision of 'debriefing' i.e. an opportunity to talk about, and learn from, difficult situations, may assist staff in responding to informal complaints.

Staff feel it would be beneficial to have a training day involving the complaints team and senior trust management where the expectations from the trust of staff were made clear in relation to complaints management.

The data informing this report show that poor staff communication patterns and poor attitudes towards service users are prominent reasons for complaints. Nevertheless staff behaviours take place in particular contexts such as poor or well functioning NHS trusts and this needs to be taken into consideration as well in discussions around complaints.

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Diagram 1: The RESPONSE project - Cycles of Action Research